STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155207	A. BUILDING 01 B. WING	11/21/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
NEW HAVEN CARE & REHABILITATION CENTER	1201 DALY DR NEW HAVEN, IN46774

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K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 11/21/11 Facility Number: 000114 Provider Number: 155207 AIM Number: 100266640 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, New Haven Care & Rehabilitation Center was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (000)	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and single station battery operated smoke detector in the resident rooms. The facility has a capacity of 120 and had a census of 101 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 12/01/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0014 SS=E	Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings has a flame spread rating of Class A or Class B. 19.3.3.1, 19.3.3.2 Based on observation and interview, the facility failed to provide documentation for the flame spread rating of interior finish materials installed within exit access for 5 of 6 corridors in the facility. This deficient practice could affect 77 residents.	K0014	Life Safety Inspection Plan of Correction December 23, 2011This plan of correction is prepared and executed as it is required by state and federal law, not because New Haven Care & Rehabilitation Center(NHCRC) agrees with the allegations and citations listed on pages 1-7 of this statement of	12/30/2011

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	Findings include: Based on observations with the Director of Maintenance on 11/21/11 during the tour from 12:10 p.m. to 3:00 p.m., carpet was installed on the bottom one third of the corridor walls throughout the facility with the exception of the 200 hall. Interview with the Director of Maintenance at 12:10 p.m. on 11/21/11, revealed no documentation was available to demonstrate the carpet provides a flame spread rating of Class A or Class B. 3.1-19(b)		deficiencies. NHCRC maintains that the alleged deficiencies do not jeopardize the health and safety of the residents, nor are they of such character so as to constitute substandard quality of care, or limit our capability to provide adequate care.Please accept this Plan of Correction as our credible allegation of compliance.1) K-014 SS = E Interior finish for corridors and exitways, including exposed interior surfaces of buildings such as fixed or movable walls, partitions, columns, and ceilings have a flame spread rating of Class-A or Class-B. 19.3.3.1, 19.3.3.2a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?NHCRC has retained a contractor to treat the effected wall covering with "Inspecta-Shield Plus" flame retardant. b) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficiency. NHCRC has retained a contractor to treat the effected wall covering with "Inspecta-Shield Plus" flame retardant.c) What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? NHCRC	

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			has retained a contractor to treat the effected wall covering with "Inspecta-Shield Plus" flame retardant.d) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systemic changes will be completed? NHCRC has retained a contractor to treat the effected wall covering with "Inspecta-Shield Plus" flame retardant. Once treated, the wall covering will be effectively modified to retard flame.**The administrator will report to the QA committee the results of audits conducted for further recommendations if needed. The Administrator/designee will monitor for compliance monthly with results forwarded to the QA committee for additional interventions if further needs are identified. By what date will the systemic changes be completed? Date of compliance 12/30/11**	
K0038 SS=E	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 19.2.1 Based on observation and interview, the facility failed to ensure 2 of 10 exit discharge paths were readily accessible at all times in accordance with LSC Section 7.1. LSC Section 7.1	K0038	1) K-038 SS = E Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1, 19.2.1a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient	01/20/2012

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	requires means of egress for buildings shall comply with Chapter 7. LSC Section 7.2.5.4 requires a ramp with a rise greater than 6 inches shall have handrails. LSC Section 7.2.2.4.2 Exception #3 states existing ramps shall be permitted to have a handrail on one side only. This deficient practice could affect residents evacuated through the exit at the end of 100 hall and the 200 hall exit in the event of an emergency. Findings include: Based on observation with the Director of Maintenance on 11/21/11 at 2:00 p.m., the 100 hall exit discharge sidewalk becomes a ramp forty three feet from the public way in the back parking lot. Additionally, the 200 hall exit discharge is a ramp that joins the 100 hall exit sidewalk. The 100 hall ramp measures forty six feet. Based on an interview with the Director of Maintenance at the time of observation, the drop in elevation from the top of the ramp to the public way is approximately three feet for both exits.		practice?NHCRC will have installed a metal fabricated handrail to the alleged deficient walkway that meets all ADA requirements. b) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficient practice. NHCRC will have installed a metal fabricated handrail to the alleged deficient walkway that meets all ADA requirements. c) What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?NHCRC will have installed a metal fabricated handrail to the alleged deficient walkway that meets all ADA requirements. d) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systemic changes will be completed? NHCRC will have installed a metal fabricated handrail to the alleged deficient walkway that meets all ADA requirements. **The administrator will report to the QA committee the results of the corrective action conducted for further recommendations if needed. The Administrator/designee will monitor for compliance**	

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	3.1-19(b)		**monthly with results forwarded to the QA committee for additional interventions if further needs are identified. By what date will the systemic changes be completed? Date of compliance** 1/20/12.	
K0048 SS=F	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to provide a written fire plan which included the use of kitchen fire extinguishers for the protection of 101 of 101 residents in the event of an emergency. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms (4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice could affect all occupants in the event of an emergency when the written fire plan should be immediately	K0048	1) K-048 SS = F There is a written plan for the protection of all patents and for their evacuation in the event of an emergency. 19.7.1.1a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?The written "Fire Plan" for NHCRC will be revised to provide for the following:I. Use of AlarmsII. Transmission of alarm to the fire dept.III. Response to alarmsIV. Isolation of fireV. Evacuation of immediate areaVI. Evacuation of smoke dept.VII. Preparation of florrs and building for evacuationVIII. Extinguishment of fire b) How will other residents having the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficiency. The written "Fire Plan" for NHCRC will be revised to provide for the following:I. Use of AlarmsII. Transmission of alarm to the fire dept.III. Response to alarmsIV. Isolation	12/23/2011

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	available. Findings include: Based on a record review with the Director of Maintenance on 11/21/11 from 12:45 p.m. to 1:13 p.m., the policy and procedure for the written fire plan was found within three separate written manuals. The Director of Maintenance made numerous trips to the administrative offices searching for the required information. Portions of the written fire plan were found in the following documentation: a) the Emergency Preparedness Policy and Procedure Manual dated 2002-2003 b) the Emergency Manual dated 2009 c) the General Orientation Manual which is used by the Director of Maintenance for training purposes Additionally, none the these manuals addressed the use of the fire extinguishers including the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen hood extinguishing system. Based on an interview with the Director of		of fireV. Evacuation of immediate areaVI. Evacuation of smoke dept.VII. Preparation of florrs and building for evacuationVIII. Extinguishment of firec) What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur?d) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systemic changes will be completed? **The administrator will report to the QA committee the amended fire plan for further recommendations if needed. The Administrator/designee will monitor for compliance monthly with results forwarded to the QA committee for additional interventions if further needs are identified. By what date will the systemic changes be completed? Date of compliance 12/23/11**	

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	Maintenance at 1:13 p.m. on 11/21/11, no other documentation was available for review. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was provided with an alarm annunciator in a location readily observed by operating personnel at a regular work station such as a nurses' station. NFPA 99, Health Care Facilities, 3-4.1.1.15 requires a remote annunciator, storage battery powered, shall be provided to operate outside of the generating room in a location readily observed by operating personnel at a regular work station. The annunciator shall indicate alarm conditions of the emergency or auxiliary power source as follows: (a) Individual visual signals shall indicate: 1. When the emergency or auxiliary power source is	K0144	4) K-0144 SS = F Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1a) What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice?Contractor hired to install proper generator alarm panel. The panel will include visual signals that shall indicate:I. When the emergency or auxillary power source is operating to supply power to load.II. When the battery charger is malfunctioningIndividual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:I. Low lubricating oil pressureII. Low water temperatureIII. Excessive water temperatureIV. Low fuel - when the main fuel storage tank contains less than a 3 hour operating supplyV. Overcrank (failed to start)VI. Overspeed b) How will other residents having	01/20/2012

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	operating to supply power to load. 2. When the battery charger is malfunctioning. (b) Individual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate: 1. Low lubricating oil pressure. 2. Low water temperature. 3. Excessive water temperature. 4. Low fuel - when the main fuel storage tank contains less than a 3-hour operating supply. 5. Overcrank (failed to start). 6. Overspeed. Where a regular work station will be unattended periodically, an audible and visual derangement signal, appropriately labeled, shall be established at a continuously monitored location. This derangement signal shall activate when any of the conditions in 3-4.1.1.15(a) and (b) occur but need not display these conditions individually. This deficient practice could affect all occupants. Findings include: Based on an observation with Director of Maintenance on 11/21/11 at 1:55 p.m., the		the potential to be affected by the same deficient practice be identified and what corrective action(s) will be taken? All residents have the potential to be affected by the alleged deficiency. Contractor hired to install proper generator alarm panel. The panel will include visual signals that shall indicate:I. When the emergency or auxillary power source is operating to supply power to load.II. When the battery charger is malfunctioningIndividual visual signals plus a common audible signal to warn of an engine-generator alarm condition shall indicate:I. Low lubricating oil pressureII. Low water temperatureIII. Excessive water temperatureIV. Low fuel - when the main fuel storage tank contains less than a 3 hour operating supplyV. Overcrank (failed to start)VI. Overspeedc) What measures will be put into place or what systematic changes will be made to ensure that the deficient practice does not recur? Contractor hired to install proper generator alarm panel. The panel will include visual signals that shall indicate:I. When the emergency or auxillary power source is operating to supply power to load.II. When the battery charger is malfunctioningIndividual visual signals plus a common audible signal to warn of an engine-generator alarm condition	

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	indicator lights for the generator at the south nurses' station will only alarm when the generator is running or if the generator fails to start. Based on an interview with the Director of Maintenance at the time of observation, the indicator lights will not go into alarm for any of the other situations listed above. Additionally, the generator panel located on the generator lacked an indicator light or alarm for low fuel in the main fuel storage tank. 3-1.19(b)		shall indicate:I. Low lubricating oil pressureII. Low water temperatureIII. Excessive water temperatureIV. Low fuel - when the main fuel storage tank contains less than a 3 hour operating supplyV. Overcrank (failed to start)VI. Overspeedd) How will the corrective action(s) be monitored to ensure the deficient practice will not recur, i.e. what quality assurance program will be put into place; and by what date the systemic changes will be completed? Contractor hired to install proper generator alarm panel. The panel will include visual signals.**The administrator will report to the QA committee the results of the revisions conducted for further recommendations if needed. The Administrator/designee will monitor for compliance monthly with results forwarded to the QA committee for additional interventions if further needs are identified. By what date will the systemic changes be completed? Date of compliance 1/20/12**	